Priority Health	BILLING POLICY No. 092
SITE NEUTRAL MEDICAL DRUG	
Effective date: Aug. 25, 2025 **Date of origin: June 19, 2025**	**Review dates: None yet recorded**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise stated
- Medicaid follows MDHHS unless otherwise stated

DEFINITION

When certain drugs covered under the medical benefit are administered in an outpatient hospital setting at a facility not directly contracted with Priority Health, these drugs must be dispensed and billed directly by a specialty pharmacy with which Priority Health has a reimbursement agreement. This helps to manage excessive drug pricing. Providers may directly submit a claim for the administration of the medication only.

Providers on the fee schedule dissatisfied with reimbursement rates may choose to follow this procurement model to reduce their risk in purchasing high-cost medications.

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Contracted pharmacy details

The following is provided for convenience regarding the current designated specialty pharmacy under this policy:

1. **Accredo Specialty Pharmacy**
    1. Prescriptions may be sent directly to Accredo Specialty.
    2. Phone: 877.222.7336
    3. Fax: 888.979.8904
2. **OptiMed Specialty Pharmacy**
    1. Prescriptions may be sent directly to OptiMed Specialty Pharmacy.
    2. Phone: 877.385.0535
    3. Fax: 877.326.2856

Allowable drug list

Review Priority Health's Medical Benefit List (MBDL) to verify the medications subject to the Site Neutral Payment Policy. All medications with Site of Service restrictions (Site of Service – YES) will be also subject to the Site Neutral Payment Policy. Providers should refer to Priority Health's Medical Benefit Drug List when determining if a requested drug for an out-of-network outpatient setting will require specialty pharmacy fulfillment. Priority Health's Medical Benefit List can be found in our Provider Manual.

Drug coverage may still require prior authorization under this policy. Drug coverage criteria can be found in our Provider Manual. If a requested drug has coverage requirements, a member or provider must submit a prior authorization request and receive a favorable coverage decision before a specialty pharmacy can bill and dispense the requested drug. The request must mention “Specialty Pharmacy” in the “Billing” section of the prior authorization form.

Updates to included drugs
Priority Health’s Medical Benefit Drug List is subject to periodic review and updates following decisions made by Priority Health’s Pharmacy and Therapeutics Committee. Priority Health may add or remove drugs as new therapies become available, as pharmacy distribution changes or as cost-effectiveness strategies evolve. Changes to the list will be reflected in the Medical Benefit Drug List with effective dates. Providers are responsible for verifying whether a medication is on the current list at the time of service.

Requests for exception to the Site Neutral Payment policy should be submitted as prior authorization requests to the Pharmacy Department at Priority Health. This can be done by faxing a completed Medical drug prior authorization form to 877.974.4411. Additional support can be provided by calling 800.942.0954.

Documentation requirements
Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

Modifiers
Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Place of service
Coverage will be considered for services furnished in the appropriate setting to the patient’s medical needs and condition. Authorization may be required. Get more information in our Provider Manual.

This policy applies to the listed drugs dispensed in an outpatient facility place of service only.

DISCLAIMER
Priority Health’s billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member’s benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member’s benefit plan or authorization isn’t being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn’t a guarantee of payment when proper billing and coding requirements or adherence to our policies aren’t followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren’t followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made